STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 88141-001**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 26th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 22, 2008, XXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on March 4, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on March 11, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). Rider CBD $1000-NP (Community Blue Deductible Requirement For Nonpanel Services), Rider CBC 50% NP (Community Blue Co-payment Requirement 50% For Nonpanel Services), and Rider CB-CM-NP $3000 (Community Blue Co-payment Maximum For Nonpanel Services) also apply. The

Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On June 8, 2007, the Petitioner underwent bi-lateral knee surgery. On June 11, 2007, he was transferred to XXXXX Hospital (XXXXX) for rehabilitation. The referral to XXXXX was provided by XXXXX, the Petitioner's surgeon, who is a nonpanel provider.

While undergoing rehabilitation at XXXXX, the Petitioner received physician services from XXXXX and XXXXX, both of whom are nonpanel (and nonparticipating) providers. BCBSM's total approved amount of $437.36 for the physicians' services was applied to the Petitioner's nonpanel deductible.

The Petitioner appealed BCBSM's decision. BCBSM held a managerial-level conference on November 26, 2007, and issued a final adverse determination dated December 13, 2007.

III
ISSUE

Did BCBSM correctly process the Petitioner's claims for the physician services provided at XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner does not understand the reasoning behind BCBSM's decision to apply nonpanel sanctions to the physician services he received at XXXXX. BCBSM says that to avoid those sanctions, the referral for services from nonpanel providers must come from the Petitioner's primary care physician. The Petitioner points out that his primary care physician referred him to XXXXX, the physician BCBSM approved to do his surgery, and XXXXX in turn referred him to XXXXX. Moreover, the Petitioner says that his primary care physician has said that he "would have been happy to sign" the referral.

The Petitioner further notes that BCBSM approved his release to XXXXX for three days of rehabilitation. He believes BCBSM is using a technicality to justify the application of the nonpanel sanctions for the physician services.

The Petitioner asserts that his care at XXXXX was medically necessary and endorsed by his primary care doctor and the surgeons that performed his surgery. Therefore, he believes that BCBSM is required to cover that care without applying nonpanel sanctions.

BCBSM's Argument

BCBSM says it correctly paid for the services the Petitioner received from nonpanel providers according to the terms and conditions of the certificate.

Nonpanel providers are physicians, hospitals, and other facilities and health care professionals who have not signed agreements to provide services under the certificate's PPO program. Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains how BCBSM pays nonpanel (and nonparticipating) providers.[1] It says that BCBSM pays its "approved amount" for physician and other professional services -- the certificate does not guarantee that charges will be paid in full. In addition, since the physicians in this case do not participate with BCBSM, they are not required to accept BCBSM's approved amount as payment in full; the Petitioner is responsible for the difference between the provider charge ($505.00) and BCBSM's approved amount ($437.36) as well as the deductible.

The amounts charged by physicians and the amounts paid by BCBSM for the petitioner's care at XXXXX is set forth in this table:

Procedure Code	Amount Charged	BCBSM's Approved Amount	Amount Paid by BCBSM	Out of Network Sanctions[2]
99253	$ 145.00	$ 123.27	$ 0.00	$ 123.27
99222	$ 160.00	$ 140.75	$ 0.00	$ 140.75

[1] Nonparticipating providers are by definition also nonpanel providers.
[2] Amounts applied to the Petitioner's $1,000.00 nonpanel deductible.

Procedure Code	Amount Charged	BCBSM's Approved Amount	Amount Paid by BCBSM	Out of Network Sanctions[2]
99231	$55.00	$ 42.51	$ 0.00	$ 42.51
99231	$ 55.00	$ 42.51	$0.00	$ 42.51
99238	$ 90.00	$ 88.32	$0.00	$88.32
Totals	$ 505.00	$ 437.36	$ 0.00	$ 437.36

Rider CBD $1,000-NP imposes a $1,000 annual deductible for care provided by nonpanel providers. BCBSM applied its entire approved amount for the physician services the Petitioner received at Metro ($437.36) to the nonpanel deductible, which had not yet been met for 2007.

BCBSM's maximum payment level for each service is determined by a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, is regularly reviewed to address the effects of changing technology, training, and medical practice, and is adjusted by geographic region.

BCBSM contends that it approved the correct amounts for the Petitioner's nonpanel care and then applied those amounts to the nonpanel deductible since the care was provided by nonpanel doctors and the referral was not made by a panel provider.

While the Petitioner maintains that his primary care physician, who is a panel doctor, was willing to refer him to XXXXX, BCBSM notes that Rider CBD $1000-NP has this requirement:

> You are not required to pay a deductible for the following covered nonpanel services when:
>
> - A panel provider refers you to a nonpanel provider
>
> **NOTE:** You must obtain the referral **before** receiving the referred service or the service will be subject to nonpanel cost sharing requirements.

Since the Petitioner did not receive a referral from panel provider before receiving nonpanel care at XXXXX, BCBSM says the nonpanel deductible applies.

Commissioner's Review

The certificate explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Panel and participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

The certificate explains this (on pages 4.26 – 4.27):

> When you receive covered services from a nonpanel provider, you will be required to pay a nonpanel deductible and a co-payment for most covered services….
>
> * * *
>
> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial….
>
> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM approved its maximum payment amount for the physician care provided the Petitioner at XXXXX. However, since those physicians were nonpanel, nonparticipating providers BCBSM applied those amounts to the $1,000 nonpanel deductible. Therefore, nothing was paid to the Petitioner for this care.

According to the certificate and applicable riders, if a panel provider refers the Petitioner to a nonpanel provider before a service is provided, the nonpanel sanctions will be waived. In this case, no information was provided to show that a panel provider referred the Petitioner to the physicians at Metro. While the Petitioner said that his primary care panel doctor was now willing to provide a referral to Metro, this does not meet the requirement that the referral be made before the service is provided. Therefore, the Commissioner concludes that the nonpanel deductible applies in this case and BCBSM was justified in applying its $437.36 approved amount to this deductible.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of July 13, 2007, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's physician's care at XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.